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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Latest Guidance on Anticoagulation in AF Patient Populations with Comorbidities

Announcer:
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Dr. Patel:
Hi, my name is Manesh Patel. I'm the chief of cardiology at Duke University and here again with another episode on the new atrial fibrillation guidelines and putting them in context. This episode, we're going to be talking about the latest guidance on anticoagulation of our atrial fibrillation patients with, I'll call them, special populations or comorbidities. So let's get started.

The first place that the guidelines speak to the importance of anticoagulation with some direction is atrial fibrillation complicating those patients who have acute coronary syndromes or PCI, percutaneous interventions. Here, there's a level of evidence, Class 1 for patients with A-fib who have increased risk of stroke, and you can imagine using a CHA_2DS_2-VASc score or others, where DOACs are preferred over vitamin K antagonists in combination with antiplatelet therapy to reduce the risk of relevant bleeding. Here, one can imagine that instead of triple therapy, lots of evidence and data to go to dual therapy with a DOAC and antiplatelet therapy, whether that's aspirin or dropping the aspirin and keeping clopidogrel or another P2Y12.

And the second recommendation, again a Class 1a, is, in most of these patients taking oral anticoagulation who undergo PCI, early discontinuation of that aspirin, as I just highlighted, and continuation of a dual antithrombotic therapy with an oral anticoagulant, like a DOAC, and a P2Y12 inhibitor is preferred over triple therapy to reduce the risk of relevant bleeding. So as you can imagine, that's, I think, mostly understood in management of our standard practice. The guidelines next go to a really important population, patients with atrial fibrillation and an intracranial hemorrhage [ICH]. And in these individuals, I think it's really important to understand some of the guidance given by the guidelines. So the guidelines start with a 2a recommendation. This is based mostly on opinion and maybe some observational data. But the thought here is that in those patients with high risk of thromboembolic stroke, so greater than 5% per year, such as rheumatic heart disease, mechanical heart valve, resumption of an anticoagulation after ICH is reasonable to reduce the risk of those thromboembolic events. So patients, unfortunately, who've had a thromboembolic risk that's so high due to rheumatic heart disease or a valve, even if they've had an ICH, you maybe should consider that, and that's a 2a.

2b is given to the next 2 groups of patients, patients with A-fib and ICH who have delayed time frame, so they're 4 to 8 weeks after the ICH. You might consider anticoagulation to balance the risk of thromboembolic and hemorrhagic complications. And the 2b is also given to these individuals who might have high risk for recurrent ICH, such as cerebral amyloid angiopathy; anticoagulation-sparing strategies such as left atrial appendage occlusion may be considered. So some guidance also thinking about those people at least 4 to 8 weeks out and potentially those that you might use a mechanical strategy for. Again, very helpful for a very complicated set of patients.

There's also recommendations for periprocedural management, and these are referenced from a variety of places, but the big take-homes here, and I'll kind of go through the Class 1 and Class 2s, and I'll sort of talk about what we shouldn't be doing. So let's start with something that's a take-home on what you shouldn't be doing, or Class 3 recommendation for harm, and that's for patients with atrial

fibrillation on warfarin who are undergoing surgeries or procedures, which they are holding warfarin. You should be holding that warfarin, except in those patients that have a valve or recent stroke/TIA [transient ischemic attack], bridging anticoagulation should be used. But otherwise, you should really not be using bridging anticoagulation. You can hold the warfarin, have the patient go through the procedure. And that's based on randomized data from bridging therapies.

The Class 1 recommendations are in those patients who have A-fib, TIA, or a stroke, excluding mechanical valves and oral anticoagulation with either warfarin or DOAC, who are scheduled to undergo surgery, you can temporarily stop that without bridging. So another sort of big message is anybody undergoing procedure, except for mechanical valve patients, you can hold bridging. And then another important piece for the guidelines is in those patients who have a thromboembolism risk greater than 5%, those undergoing pacemaker or defibrillator implantation or generator change, continuing the anticoagulation is recommended, whether it's with warfarin or DOAC. And so here I think it's important to recognize there's an opportunity to continue it with warfarin. In DOAC, it's often held the day of and that's an important feature, and that's a 2a recommendation to consider holding that DOAC the day of that procedure.

So in general, procedural management is mechanical valve, you should consider bridging, everyone else, don't bridge them. Those undergoing implantation of a pacemaker or defibrillator, continue the warfarin. You might be reasonable to hold the DOAC the day of.

A couple of other things I think it's important to recognize, is atrial fibrillation in patients with peripheral artery disease, chronic coronary disease, again, it's important to recognize that you can drop the aspirin in those patients, and the guidelines speak to that. And then finally, for patients with rheumatic heart disease, DOAC should not be used, but we should be considering warfarin.

All right, well, thanks for listening to my episode on special populations and management of atrial fibrillation going in and out of procedures.

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